STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF DUNELAND, THE	110 BEVERLY DR CHESTERTON, IN46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint IN00089829. Complaint IN00089829 unsubstantiated due to a lack of evidence. Survey dates: May 9, 10, 11, and 13, 2011 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Survey team: Regina Sanders, RN, TC Sheila Sizemore, RN Marcia Mital, RN (May 9, 2011) Census bed type: SNF/NF: 96 Total: 96 Census payor type: Medicare: 16 Medicaid: 70 Other: 10 Total: 96 Sample: 20 Supplemental sample: 1	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 5-16-11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation, and interview, the facility failed to follow physician's orders related to a blood pressure medication and insulin for 2 of 20 residents reviewed for physician's orders in a sample of 20. (Residents #7 and #15) Findings include: 1. Resident #7's record was reviewed on 05/10/11 at 9:20 a.m. The resident's diagnoses included, but were not limited to, hypertension and end stage renal disease. A Physician's Order, dated 04/26/11, indicated an order for Clonidine (anti-hypertensive) 0.1 milligrams, twice a day as needed for systolic (top number) blood pressure more than 150 and/or diastolic blood pressure (bottom number) more than 90.	F0282	Plan of Correction F282The facility does provide qualified persons in accordance with each residents written plan of careI. The actions taken by the facility are as follows:Regarding R7 the physician was notified on 5/11/2011 at 11AM in regards to R7 not receiving PRN Clonidine as ordered. No new orders were received. On 5/16/2011 an order was received to discontinue the PRN Clonidine.Regarding R15 the physician was notified on 5/12/2011 at 9:15AM in regards to R15 receiving 2 units of Novolog insulin instead of 3 units. No new orders were received.II. The facility's actions taken to identify other residents are as follows:100% review of all residents for PRN Clonidine were reviewed by D.O.N.. No other residents had orders for PRN Clonidine.100% review of all residents receiving sliding scale insulin were reviewed by the D.O.N.. No further issues were	05/20/2011

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	The Medication Administration Record (MAR), dated 05/11, indicated the resident's blood pressure was 163/98 at 9 a.m. on May 2, 2011. The Medication Administration Record, dated 05/11, and the Nurses' Notes, dated 05/02/11, lacked documentation to indicate the resident received the Clonidine as ordered by the physician. During an observation on 05/10/11 at 11 a.m., with the Director of Nursing present, the resident had an unopened box of Clonidine 0.1 milligrams in the medication cart. During an interview on 05/10/11 at 11 a.m., the Director of Nursing indicated the Clonidine had not been given as ordered for the high blood pressure. 2. Resident #15's record was reviewed on 05/11/11 at 11:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. The Physician's Recapitulation Orders, dated 05/11, indicated an order for Novolog insulin to be given per the blood sugar result (sliding scale), four times daily. The order indicated for a blood sugar 151-200 to give three units of		identified.III. The measures put into place by the facility are as follows.The licenced nursing staff were re-inserviced on following physicians orders on 5/13/2011 and 5/14/2011.The D.O.N./designee will review any new PRN Clonidine orders when received and review 3 times a week and as needed.The D.O.N./designee will audit all residents with sliding scale insulin orders 3 times a week and as needed.IV. The facility will moniter actions as follows:The D.O.N./designee will review any new PRN Clonidine orders when received and review 3 times a week and as needed.The D.O.N./designee will audit all residents with sliding scale insulin orders 3 times a week and as needed.The audits will be reviewed in the Quarterly Quality Improvement Meeting.The Quality Improvement Committe will determine the end date for the audits.	

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	insulin. The MAR, dated 05/11, indicated the resident's blood sugar was 156 at 6 a.m. on 05/01/11 and two units of insulin was given at 7 a.m. During an interview on 05/11/11 at 12:10 p.m., LPN #2 indicated three units of insulin should have been given instead of two units of insulin. 3.1-35(g)(2)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview the facility failed to ensure a resident who required assistance for eating received staff assistance during a meal for 1 of 6 residents who required staff assistance in a sample of 20 residents. (Resident #10) Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed table, which consisted of pureed beans,	F0312	Plan of Correction F312The facility does ensure residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygine.I.The actions taken by the facility are as follows:Regarding R10. R10 expired on 5/10/11.II. The facility's action taken to identify other residents are as follows:All residents who need assistance with meals while in bed were reviewed and no further issues identified.III. The measures put into place are as follows:Nursing staff was reinserviced on 5/13/2011 and 5/14/2011 for assistance with feeding residents in bed, who	05/20/2011

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	hotdog, and strawberry shortcake. There were two cartons of mighty shakes (supplement), one had been opened and poured into a four ounce glass. The other mighty shake remained unopened. The resident held a bottle of sweet tea in his hand. There were no staff present in the resident's room. Resident #10 was observed on 5/09/11 at 12:31 p.m., 12:40 p.m., 12:41 p.m., 12:50 p.m., 12:55 p.m. with no staff present in the resident's room. The resident's meal remained untouched by the resident. An observation at 1:05 p.m., indicated the resident's meal tray had been removed from the room. During an interview on 5/09/11 at 1:07 p.m., CNA #1 indicated She had taken the resident's meal tray. She indicated she had not fed the resident. She indicated she did not work the 100 hall. She indicated she was a hall monitor and was answering call lights. Observation of the resident's meal tray in the food rack indicated the resident's noon meal went untouched. During an interview on 5/09/11 at 1:08 p.m., LPN #2 indicated the resident was capable of feeding himself. LPN #2 indicated the resident needed to be sitting in an up right position. LPN #2 indicated		need the assistance.Licensed nursing staff will do daily rounds and document for all residents who eat in bed for proper positioning and need for assistance for all meals.IV. The facility will monitor actions as follows.Licensed nursing staff will do daily rounds and document for all residents who eat in bed for proper positioning and need for assistance with meals for all meals. The audits will be reviewed in the Quarterly Quality Improvement Committee Meeting.The Quality Improvement Committee wil determine the end date for audits.	

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the resident "would only drink mighty shakes and juice."

During an interview on 5/09/11 at 1:40 p.m., the DoN (Director of Nursing) indicated the resident was able to feed himself. The DoN indicated the resident should be sitting up better.

Resident #10's record was reviewed on 5/09/11 at 11:45 a.m. Resident #10's diagnoses included, but were not limited to, anorexia, advanced malnutrition, failure to thrive, and dysphagia (difficulty swallowing). Resident #10 was placed on Hospice on 5/02/11.

An admission MDS (Minimum Data Set) assessment, dated 4/27/11, indicated Resident #10 had short term memory problems and was moderately impaired for decision making. The admission MDS assessment indicated the resident required extensive one person assist for eating.

A care plan for "potential for aspiration r/t (related to) dysphagia delay in swallow and cough to clear throat after swallow," dated 4/27/11, indicated "...Observe ability when eating. Assist with meals as needed. Monitor for s/s (signs and symptoms) aspiration elevated temp, difficulty swallowing, adventitious lung

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	sounds...." A care plan for ADLS (Activities of Daily Living), dated 4/25/11, indicated "...Assist as needed...." 3.1-38(a)(2)(D)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure a catheter tubing was positioned correctly to reduce the risk for infection for 1 of 5 residents with indwelling catheters in a sample of 20 residents reviewed for indwelling catheters. (Resident #19) Findings include: Resident #19 was observed on 5/9/11 at 11:44 a.m., 12:28 p.m.,and 12:43 p.m.,with her foley catheter tubing laying on the floor. The resident was in the	F0315	Plan of Correction F315The facility does ensure that a resident who enters the facility without an indwelling catheter is not catherized unless residents clinical condition demonstrates that catherization was necessary: and a resident who is incontinient of bladder receives appropriate treatment and services to prevent UTI's and to restore as much normal bladder function as possible.I.The actions taken by the facility are as follows:Regarding R19. Foley catheter was corrected as soon as surveyor brought it to the D.O.N.'s attention. Physician was	05/20/2011

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	rehabilitation dining room being fed by staff. Resident #19 was observed on 5/10/11 at 11:20 a.m., and 11:30 a.m.,, with her foley catheter tubing on the floor in the rehabilitation dining room. During an interview on 5/10/11 at 11:33 a.m., the DoN (director of Nursing) indicated the catheter tubing should not be on the floor. Resident #19's record was reviewed on 5/10/11 at 11:36 a.m. Resident #19's diagnoses included, but were not limited to, hypertension, multiple pressure sores, and dementia. The physician's orders, dated 3/26/11, indicated the resident had a 16 french foley catheter. A facility policy, dated 1/07, titled "Urinary Catheter Insertion/Catheter Care," indicated "...Maintain the system on a daily basis by keeping the drainage system free of kinks in the tubing, maintain below the level of the bladder and keep drainage system off the floor...." 3.1-41(a)(2)		notified on 5/17/2011 at 3:30PM regarding foley catheter tubing on the floor. No new orders received.II. The facility's action to identify other residents are as follows:All residents with foley catheter were assessed for proper placement of foley catheter tubing. No further issues identified.III. The measures put into place by the facility are as follows:Nursing staff was re-inserviced on 5/13/2011 and 5/14/2011 for proper placement of foley catheter tubing.Nursing staff will complete an audit daily from 6:30AM to 8:30PM for proper placement of all residents with foley catheters.IV. The facility will moniter actions as follows:Nursing staff will complete and audit daily from 6:30AM to 8:30PM for proper placement of all residents with foley catheters.The audits will be reviewed in the Quarterly Quality Improvement Committee Meeting.The Quality Improvement Committee will determine the end date for audits.	

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision during meal times for 1 of 6 residents who had swallowing problems in a sample of 20. (Resident #10). Findings include: Resident #10 was observed on 5/09/11 at 12:16 p.m., laying in his bed with the head of the bed at a 30 degree angle. His noon meal was placed on the overbed table, which consisted of pureed beans, hotdog, and strawberry shortcake. There were two cartons of mighty shakes (supplement), one had been opened and poured into a four ounce glass. The other mighty shake remained unopened. The resident held a bottle of sweet tea in his hand. There were no staff present in the resident's room. Resident #10 was observed on 5/09/11 at 12:31 p.m., 12:40 p.m., 12:41 p.m., 12:50 p.m., 12:55 p.m. with no staff present in the resident's room. The resident's meal remained untouched by the resident. An observation at 1:05 p.m., indicated the	F0323	Plan of Correction F323The facility does ensure that the residents environment remains free of accident hazards and each resident does receive adequate supervision and assistive devices to prevent accidents.I.The action taken by the facility are as follows:Regarding R10. R10 expired on 5/10/2011.II. The facility's action taken to identify other residents is as follows:All residents who need assistance with meals wihile in bed were reviewed and no further issues identified.III. The measures put into place are as follows:Nursing staff was reinserviced for assistance with feeding residents in bed who need the assistance and for proper positioning on 5/13/2011 and 5/14/2011.Licensed nursing staff will do daily rounds and document for proper positioning and the need for assistance with meals.IV. The facility will moniter actions as follows:Licensed nursing staff will do daily rounds and document for proper positioning and the need for assistance with meals.The audit will be reviewed at the Quarterly Quality Improvement committee Meeting.The Quality Improvement Comittee will determine the end	05/20/2011

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	resident's meal tray had been removed from the room. During an interview on 5/09/11 at 1:07 p.m., CNA #1 indicated She had taken the resident's meal tray. She indicated she had not fed the resident. She indicated she did not work the 100 hall. She indicated she was a hall monitor and answering call lights. Observation of the resident's meal tray in the food rack indicated the resident's noon meal went untouched. During an interview on 5/09/11 at 1:08 p.m., LPN #2 indicated the resident needed to be sitting up in a more upright position. During an interview on 5/09/11 at 1:40 p.m., the DoN (Director of Nursing) indicated the resident should be sitting up better. Resident #10's record was reviewed on 5/09/11 at 11:45 a.m. Resident #10's diagnoses included, but were not limited to, anorexia, advanced malnutrition, failure to thrive, and dysphagia (difficulty swallowing). Resident #10 was placed on Hospice on 5/02/11. An admission MDS (Minimum Data Set) assessment, dated 4/27/11, indicated		date for audits.	

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	Resident #10 had short term memory problems and was moderately impaired for decision making. The admission MDS assessment indicated the resident required extensive one person assist for eating. A care plan for "potential for aspiration r/t (related to) dysphagia delay in swallow and cough to clear throat after swallow," dated 4/27/11, indicated "...Observe ability when eating. Assist with meals as needed. Monitor for s/s (signs and symptoms) aspiration elevated temp, difficulty swallowing, adventitious lung sounds...." A care plan for ADLS (Activities of Daily Living), dated 4/25/11, indicated "...Assist as needed...." A hospital modified barium swallow evaluation report (swallowing test), dated 4/29/11, indicated "Pt (patient) presents with severe orophanyngeal dysphagia secondary to decreased airway protection resulting in aspiration....." During an interview on 5/11/11 at 11:17 a.m., the Speech Therapist indicated the resident should be in an upright 90 degrees sitting position when consuming food and liquid. The Speech Therapist indicated there was a possibility of			

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	aspiration. A facility policy, titled "Eating Support," dated 1/07, indicated "...Assist the resident to a proper sitting position...." 3.1-45(a)(2)			